

he was then recommended to Mr. Taunton, in Hatton Garden; who informed him it was a varicocele; and the scrotum was directed to be supported, and an evaporating lotion to be used.

"On July 20, 1837, I removed a large portion of the relaxed scrotum which covered the swelling, in the presence of Mr. James Babington; secured some small arteries; and then used four sutures, to approximate the edges of the scrotum. He was sent from my house, in a coach, to Chelsea, after the operation; and the scrotum very soon healed, and the uneasy sensation in the part vanished.

"CASE IV. Mr. John K——, aged 25, four months ago found the scrotum enlarged on the left side, with occasional pain in the part, which darted upwards to the external abdominal ring. It gradually increased, until it was three times larger than the right side of the scrotum, became more painful, and occasioned much depression of spirits. On the 15th of October, 1837, I removed a portion of the scrotum, by passing a needle and thread through it in three different places, and cutting away the scrotum beyond them. This plan did not facilitate the operation, and made the tying of the arteries more difficult; but it succeeded in relieving the disease."

A case is also given, communicated by Mr. Key.

In one case Sir Astley raised the scrotum, and placed a ligature around the part which he designed to remove, drawing the thread quite tight: but it produced a great deal of pain; the part sloughed with considerable constitutional irritation, and after a great length of time, and with more suffering than the complaint justifies.

It must be distinctly understood that the removal of a portion of the scrotum is recommended in those cases only of spermatocele, in which the patient suffers great local pain; in cases in which he is most urgent to have the swelling and deformity of the part removed; and more especially in those instances in which the function of digestion suffers, and there is a great degree of nervousness and of mental depression. For slighter cases, a suspensory bandage must be still recommended.

OPHTHALMOLOGY.

44. *On a new means of Diagnosis between Amaurosis and Cataract.* By M. SANSON.—If a light be presented before an amaurotic eye—the pupil of which is either naturally or artificially dilated—three distinct images of the flame may be invariably observed. Of these three images two are upright, and one is *reversed*: they are situated, the one behind the other, in the following order. The anterior one, which is also most distinct, is one of the former or *upright* images. The posterior or deepest, which is the least distinct, is also one of the upright images. The intermediate image is the *reversed* one.

This last or reversed image is paler than the first, but brighter than the second, upright one; and it also differs in this circumstance, that, when the light is moved to either side or round the eye, it is separated from the other two images so as always to occupy the opposite side, while they (the upright ones) are seen to follow the position of the light, moving to the right or left, upwards or downwards, according as the candle is moved in any of these directions.

If the candle be held opposite to the axis of the eye, all the three images are situated one behind the other—the two posterior ones being, as a matter of course, masked and obscured by the anterior one. But if it be held to a—say the right—side, then the reversed image will be seen in the opposite or left angle of the eye, while the upright ones are seen at its right angle.

If it be moved around the eye, the upright images follow it together, while the reversed image, although describing the circle in the same direction, is always at the opposite end of the eye's diameter.

The unpractised observer may experience some difficulty in observing these phenomena.

The patient should be placed in a dark chamber; and let us suppose that the candle is held at the external angle of the eye: the anterior upright image, which is large and brilliant, will be observed at the outer and upper part of the pupil. If

we now look very attentively into the bottom of the eye, the reversed image will be seen at about one line's breadth from the preceding upright image, and at the meeting of the lower with the middle third of the diameter of the pupil—the right extremity of which (the diameter) is occupied with the anterior upright image.

If the surgeon does not detect these phenomena at first, he has only to move the light upwards and downwards, once or twice, fixing his look steadily on the pupil, and he cannot fail to observe that one image rises and the other descends.

As to the posterior or deep-seated upright image, it is always very difficult to perceive it, in consequence of its paleness, and of the intervention of the other upright one—of which it looks like the shadow.

M. Sanson assures the surgeon that, when once they have detected the very images, they will always readily perceive them afterwards, *provided there be no obscurity or opacity of the lens.*

Whenever a cataract exists, no matter what may be the stage or progress of the disease, none of the images, described above, are ever perceptible.

Some time ago (says M. Sanson,) a patient was sent to me from a great distance to be relieved by operation from a cataract: *the three images were perceived; the patient was affected with glaucoma.*

A few days ago I was desired to visit a patient, who had been pronounced by several medical men in the metropolis to be affected with cataract: I perceived the three images and declared the case to be one of amaurosis.

A woman, whose sight was entirely lost, was lately sent to my care as an amaurotic patient. There was no opacity visible in the field of the pupil; but two of the images were absent. I gave it as my opinion that she had two cataracts; and the accuracy of this diagnosis has been subsequently confirmed.

The preceding remarks were made by M. Sanson, one of the surgeons of the Hôtel Dieu in Paris, in his course of lectures on ophthalmology during last year. He had first noticed the phenomena, described above, about twelve months previously; and he had availed himself of his ample opportunities in the hospital during this period to test the accuracy of his opinion. He assures us that his experience has quite satisfied him of its truth.—*Med. Chirurg. Rev., from l'Expérience; Journal de Med. et Chirurg.*

45. *Xerophthalmia.*—The following well marked example of this rare disease is recorded, by M. VÉLPEAU, in the *Gazette Médicale de Paris*. A young man, of a robust, although somewhat scrofulous constitution, had, twelve months before his admission into the hospital, suffered from inflammation of the right eye. An abscess formed at the time under the upper eyelid, and gave discharge to a quantity of pus from its inner surface. When this discharge ceased, the patient began to experience dull pains at the external part of the eye, also a gradual diminution of the lachrymal secretion and dimness of vision.

Various means were used, but without effect; and the surface of the cornea became quite dry, and the sight most indistinct.

When admitted into the hospital, it was observed that his right upper eyelid was somewhat inverted, and could not be elevated so much as the left one. The orifices of the meibomian glands and of the inferior lachrymal punctum were quite obliterated.

The caruncula lachrymalis was observed to be smaller than that of the other side, and imbedded in a triangular fold of the conjunctiva. This membrane presented a dull white colour, and was perfectly dry.

At both angles of the eye, it exhibited several vertical folds, which seemed to be more distinct and numerous in consequence of the efforts which the patient had made to separate the eyelids as much as possible.

When the eye-ball was drawn into the socket, the lower segment of the cornea seemed to be tied by one of these folds, as by the *membrana nictitans* in birds. The surface of the cornea itself was invested with a pulverulent pellicle, which was dry and unequally opaque. Through it, as through a cloud, the iris and pupil might be perceived. In short, the eye looked like the dry, dull and withered eye of a corpse, which had been exposed for a day or two to the action of the air; only with this exception, that it was not at all sunk in the socket. The patient had found that his sight was always clearer, if he moistened the surface